Exhibit J

VACCINE		DATE GIVEN	DOCTOR OFFICE OR CLINIC	DATE NEXT DOSE DUE
HEPATITIS B	1			
	2			
	3			

TB SKIN TESTS Pruebas de la Tuber-culosis	Type*	Date given	Given by	Date read	Read by	mm indur	Impression
	☐ PPD-Mantoux ☐ Other ____	/ /		/ /			☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other ____	/ /		/ /			☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other ____	/ /		/ /			☐ Pos ☐ Neg

* If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive.)

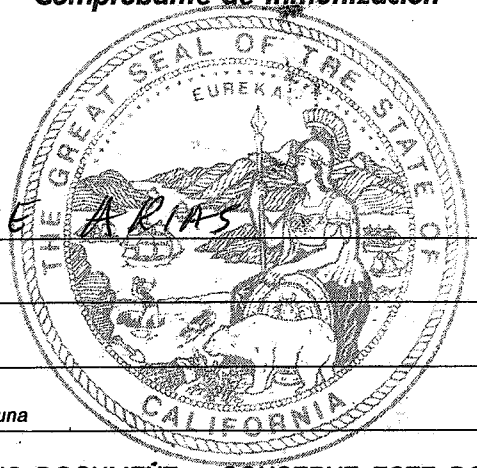
Film date: ____/____/____ Impression: ☐ normal ☐ abnormal
Person is free of communicable tuberculosis: ☐ yes ☐ no

Signature/Agency: _____

Parents: Your child must meet California's immunization requirements to be enrolled in school. Keep this Record as proof of immunization. **Padres:** Su niño debe cumplir con los requisitos de vacunas para ser admitido a la escuela. Mantenga este Comprobante: lo necesitará.

IMMUNIZATION RECORD

Comprobante de Inmunizacion



Name
nombre NOE ARIAS

Birthdate
fecha de nacimiento

Allergies
alergias

Vaccine Reactions
reacciones a la vacuna

RETAIN THIS DOCUMENT — *CONSERVE ESTE DOCUMENTO*

Name Sex Birthdate

VACCINE *vacuna*		DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico a clínica*	DATE NEXT DOSE DUE *próxima vacuna*
POLIO	1	10/29/91		
	2	4/3-92		
	3	3/3/93	SVCHC	9/93
	4			

VACCINE *vacuna*		DATE GIVEN *fecha de vacunación*		DOCTOR OFFICE OR CLINIC *médico a clínica*	DATE NEXT DOSE DUE *próxima vacuna*
DTP Td DT	1	10/29/91	☒ DTP ☐ Td ☐ DT		
	2	4/3/92	☒ DTP ☐ Td ☐ DT		
	3	3/9/93	☐ DTP ☒ Td ☒ DT	SVCHC	9/93
	4		☐ DTP ☐ Td ☐ DT		
	5		☐ DTP ☐ Td ☐ DT		
			☐ DTP ☐ Td ☐ DT		

VACCINE *vacuna*		DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico a clínica*	DATE NEXT DOSE DUE *próxima vacuna*
HIB	1			
	2			
	3			
	4			

VACCINE *vacuna*		DATE GIVEN *fecha de vacunación*		DOCTOR OFFICE OR CLINIC *médico a clínica*	DATE NEXT DOSE DUE *próxima vacuna*
MMR	1	10/29/91	☐ MMR ☐ MR ☐ Meas		
	2	4/3/92	☐ MMR ☐ MR ☐ Meas		

DTP = diphtheria, tetanus, pertussis (whooping cough) difteria, tétano y tos ferina
MMR = measles, mumps, rubella sarampión, paperas y sarampión aleman
HIB = Hib meningitis (Haemophilus influenzae B) meningitis Hib

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VACCINE *vacuna*	DATE GIVEN *dada en la fecha*	DOCTOR OR CLINIC *doctor o clínica*	MEDICAL NOTES *notas del médico*	DATE NEXT DUE *fecha en que debe darse siguiente*
MEASLES *sarampión (de 10 días)*	10/29/91			
RUBELLA *sarampión alemán (de 3 días)*				
MUMPS *paperas*				
MMR #2	4/3/92	SANTA ROSA MEMORIAL HOSPITAL MOBILE HEALTH CLINIC 1165 MONTGOMERY DR., SANTA ROSA, CA 95405 707-525-4268		

THIS RECORD MUST BE PRESENTED AT SCHOOL REGISTRATION
Este Registro tendrá que presentarse en la matriculación

IMMUNIZATION RECORD
Registro de Inmunizacion

Name *nombre* Noe Arias Ordoñez

Birthdate *fecha de nacimiento* 2/10/81

Allergies *alergias*

Vaccine Reactions *Reacciones a la vacuna*

RETAIN THIS DOCUMENT • *CONSERVE ESTE DOCUMENTO*

VACCINE *vacuna*		DATE GIVEN *dada en la fecha*	DOCTOR OR CLINIC *doctor o clínica*	MEDICAL NOTES *notas del médico*	DATE NEXT DUE *fecha en que debe darse siguiente*
POLIO *poliomelitis*	1				
	2	10/29/91			
	3	4/3/92	SANTA ROSA MEMORIAL HOSPITAL MOBILE HEALTH CLINIC 1165 MONTGOMERY DR., SANTA ROSA, CA 95405 707-525-4263		
	4				
	5			optional/*opcional*	
DPT/DT Diphtheria, Pertussis (whooping cough) and Tetanus *difteria, tos ferina y tetanos*	1				
	2	10/29/91			
	3	4/3/92	SANTA ROSA MEMORIAL HOSPITAL MOBILE HEALTH CLINIC 1165 MONTGOMERY DR., SANTA ROSA, CA 95405 707-525-4263		
	4				
	5				

PRESENT THIS RECORD AT EACH VISIT
En cada visita por favor muestre este Registro de Inmunizacion

△ OSP

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VACCINE		DATE GIVEN	DOCTOR OFFICE OR CLINIC	DATE NEXT DOSE DUE
HEPATITIS B	1			
	2			
	3			

TB SKIN TESTS Pruebas de la Tuber-culosis	Type*	Date given	Given by	Date read	Read by	mm indur	Impresion
	☐ PPD-Mantoux ☐ Other ____	12/10/92	BZ	12/15/92		10mm x 20mm	☑ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other ____	/ /		/ /			☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other ____	/ /		/ /			☐ Pos ☐ Neg

* If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive.) Film date: ____/____/____ Impression: ☐ normal ☐ abnormal
Person is free of communicable tuberculosis: ☐ yes ☐ no
Signature/Agency: _____

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IMMUNIZATION RECORD

Comprobante de Inmunizacion

Name *nombre* Noe Arias Ordonez

Birthdate *fecha de nacimiento*

Allergies *alergias*

Vaccine Reactions *reacciones a la vacuna*

RETAIN THIS DOCUMENT — *CONSERVE ESTE DOCUMENTO*

Name Sex Birthdate

VACCINE *vacuna*		DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico a clínica*	DATE NEXT DOSE DUE *próxima vacuna*
POLIO	1			
	2	10/29/91		
	3	4/3/92	SRMH	
	4			
DTP Td DT	1		☐ DTP ☐ Td ☐ DT	
	2	10/29/91	☐ DTP ☐ Td ☐ DT	
	3	4/3/92	☐ DTP ☐ Td ☐ DT SR MH	
	4		☐ DTP ☐ Td ☐ DT	
	5		☐ DTP ☐ Td ☐ DT	
			☐ DTP ☐ Td ☐ DT	
HIB	1			
	2			
	3			
	4			
MMR	1	10/29/91	☐ MMR ☐ MR ☐ Meas	
	2	4/3/92	☐ MMR ☐ MR ☐ Meas	

DTP = diphtheria, tetanus, pertussis (whooping cough) difteria, tétano y tos ferina
MMR = measles, mumps, rubella sarampión, paperas y sarampión aleman
HIB = Hib meningitis (Haemophilus influenzae B) meningitis Hib

PM 298 (7/91) **IMPORTANT: SEE OTHER SIDE** 91 61331